Dear Dental Council Colleagues,

Thankyou for the opportunity to respond to the proposal to lift the age restriction for scope of practice of OHT's.

I understand one of the main aims for this proposal is to make primary dental care more accessible to more people. For this to be the case I can only assume charges for these primary services are expected to be much lower than if a Dentist performed the same procedure. I can also assume it is anticipated by DCNZ the quality of an OHT's adult restorative work will be equivalent to that of a dentist.

So firstly let's look at potential charges reduction for increased accessibility by lower income people.
For an OHT to work effectively in the manner proposed, a Dental Assistant would be required on top of the rent of the rooms, equipment, materials, insurances, continued education, power, software & I.T. support and guidance support by Dentist/Specialist.
If an OHT were to work 40hrs a week for 45 weeks/yr, was busy 100% of the time, and had an assistant, a private practice would need to charge $185/hr. If less than 40hrs/wk, say 32hrs, and perhaps less weeks of the year worked, or increased downtime due to say maternity/sick leave, and knowing that FTA appointments are prevalent in this group, Then this hourly charge out rate would need to increase to say $250-$300/hr.
For an OHT to perform to an adequate standard for the proposal, an hour would need to be allocated to cover a restorative procedure including note taking and sterilisation.

So my first question is, is this an acceptable reduction in fee for lower income people? Is this producing the desired financial effect? And are DHB's expected to fund this or is it purely user pays? If DHB's I can only assume they would follow the MOH model in which case $86 for a restoration is not going to be financially viable for a private practice. This is why very few dentists belong to the MOH adolescent contract, their fees make no financial sense and private practices go backward financially, being propped up by the hygiene appointments.

Secondly, quality.
My concern is around restorative quality. Currently in my opinion the quality of restorations performed by new grad OHT's and their confidence (or lack of) is severely underspec. In order for any change in restorative scope to occur I would need to see a major shift in how restorative training is carried out in OHT courses. If the current standard is maintained and scope age limit lifted, then in my opinion it could cost the lower income patient more in the long term than if done well by a good dentist originally, either in multiple flg replacements or in eventual root therapy of extraction. Or it could cost the dentist/specialist in downtime to redo work especially if DHB's are funding (or not funding as the case may be).
So to achieve the necessary level of clinical confidence and quality there would need to be a substantial increase in training quality, in time, number of instructors, variety of cases, variety of complexity. To do this would greatly increase the cost of training, and if this was passed on to OHT's then they would need to be paid more, thereby increasing patient fees and defeating the original objective.
If the government funded this increase in training, then another area in their budget may need to be reduced.
It may be another option for the government to decide rather than spend more in extra training to finally subsidise all dental care for all citizens, not just under 18 which is long overdue, perhaps by creating an ACC-style medical/dental scheme.

My submission probably created more questions than answers unfortunately.

I hope this helps with your decision making process. Please feel free to call me to discuss further.

Kind Regards
Dr Anthony Hunt
[redacted]